WHAT CASES OF INSANITY SHALL WE TREAT AT HOME?

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A FEAR of the non-asylum treatment of insanity widely obtains in the profession, not so much because of the invariably superior advantages of the asylum as because of lack of familiarity with mental disease and the general idea that most cases of insanity are dangerous either to themselves or to those about them. This fear has prevented recognition of the fact that asylums have their disadvantages just as undoubtedly as they have their advantages, and has seemingly retarded proper appreciation of the significance of the almost universal abolition of restraint in asylums within the last few years. To send a patient to one of these institutions is to cast a suspicion of mental integrity upon the whole future career of that individual, whilst cases even of a much severer type of insanity than that for which the patient may have been committed will, when treated at home, be regarded lightly by the laity under some such vague name as brain fever, delirium, inflammation of the brain, etc., and will soon be forgotten in business and social circles. My experience of the practice of medicine has convinced me beyond a peradventure that for many curable insanities no hospital can take the place of a home in which a wife, a mother, a sister, or friends will watch a patient and a patient's nurse with the keen eyes of affection. Again, the physician is under infinitely more stimulus to be on the alert in a home wherein he attends one individual, under the observation of an interested family, than when he has a hundred or more patients under his care in hospital wards. On the other hand, violence, especially if it be long continued, is best controlled in the specially equipped wards of an asylum, as are also suicidal, homicidal, and uncleanly lunatics; moreover, some active conditions of lunacy are best left without medicine, and allowed to roam harmlessly about within certain limits, and it may be impossible to permit this play of the so-called *vis medicatrix naturæ* in a private house; many chronic cases, too, needing only housing and supervision, will have much more freedom and comfort in asylum wards and grounds; and, finally, lack of pecuniary means may make it absolutely impossible to keep the patient at home. In other words, there is no reason why the question of the home or asylum treatment of a case of insanity should not be determined by the same considerations as determine the home or hospital treatment of an ordinary case of sickness. Why should we not treat a case of insanity at home when it is possible to do it, and as long as it does not become absolutely necessary, either from the nature of the case or the patient's circumstances or environment, to send it to

a hospital? The object of this paper is to attempt to delimit cases proper for home treatment from those fit only for treatment in asylums.

The three mental conditions forming the basis of all classifications of insanity, are mania, melancholia, and dementia. An excellent idea of these three conditions can be obtained if a diagram be imagined in which a line is drawn to represent the ordinary condition of mental health, which, we all know, has decided variations within perfectly normal limits, from high spirits on the one hand to mental depression upon the other. A mania may be represented as an increase of the cerebral reflexes upward above the boundaries of this normal line, whilst melancholia may be represented as a decrease of the cerebral reflexes below this normal line; and we may, in this diagrammatic way, represent dementia as a cessation of even the limited cerebral reflexes within the normal limits. All these three main types—mania, melancholia, dementia—may be practically indistinguishable in their slighter degrees from normal mental conditions, although, as a matter of fact, even the slightest forms are apt to think or act or speak in some abnormal way which is so totally at variance with the patient's character as to indicate to a medical observer that the cellular action of the brain is deranged. The classification of insanities is based upon the intensity, duration, and sequence of these three cardinal symptoms—mania, melancholia, dementia—as well as upon their association with certain physical symptoms. In other words, the insanities are of two kinds, one in which the symptoms are purely mental, the other in which they are both mental and physical. We can obtain a better idea of the reason for this difference when we review for a moment our present knowledge of the cortex of the brain.

No one nowadays would be rash enough to deny that the cortex is the organ of the mind in so far as the structural integrity of the former is absolutely necessary for the healthy manifestations of the latter. The old, old doctrine of cortical localization, vaguely outlined by the early Arabians and in the Middle Ages carried into the ridiculous phrenological absurdities of Gall and Spurzheim, and given its first anatomical basis by Bouillaud, Marc Dax, and Broca, has made very considerable progress within the last eighteen years, so that at the present time we can localize accurately a number of so-called *centres*, as of the upper and lower extremities, head, neck, face, motor mechanism of speech, mental mechanism of hearing, sight.[1] Professional interest in this question of localization is so great at the present moment that every month adds definitely to our knowledge, and it is extremely probable that we stand on the threshold of an almost indefinite multiplication of these so-called

[1] Further details in this branch of the subject will be found in my article on "Our Present Knowledge of Localization in the Cortex Cerebri." N. Y. Med. Journ., June 18, 1887.

centres. But these centres are only terminal stations of certain nerve fibres in the cortical gray matter, and a disease of one of these termini leads only to impairment in the conducting power of these nerve fibres, and is not necessarily productive of any mental symptoms. Thus, a patient may be mentally intact, and yet have destruction of an arm centre sufficient to cause paralysis of the corresponding arm; or another patient, unable to recognize the meaning of spoken words, may be otherwise unimpaired in mind, and so it may be with a patient who has lost the ability to pronounce words, or who has become blind in symmetrical halves of each retina. Over and above any affection of these centres there may be a total mental alteration, but we do not know what portion of the cortex we are to regard as the site of pure mental alteration. There has been, to be sure, a strong tendency to regard the anterior portions of the frontal lobe as the site of mind pure and simple, but it is probable that mind will be found to be composed of a great variety of centres. However this may be, it suffices our present purpose to understand clearly that certain diseases of the cortex may be purely mental in their symptoms, that certain others may be entirely physical, whilst others still may present both mental and physical phenomena. With the purely physical this paper does not deal. Of the others, it may be said that the combination of physical and mental symptoms is always of evil augury, whilst the prognosis of the purely mental types is variable.

Cases favorable for home treatment may be catalogued as follows:

Subacute mania;

Melancholia that is non-hallucinatory and without great agitation, præcordial fear, or stupor;[1]

Many cases of primary dementia;

Many cases of post-febrile and so-called puerperal insanities;

Insanity of doubt;

Most cases of epileptic insanity;

Some cases of hysterical and periodical insanity, as well as of the so-called circular varieties;

Certain insanities of pubescence;

The insanities of childhood.

When mania of a mild type occurs in a robust individual who is not of an advanced age, either without delusions or hallucinations, or having these only in slight degree, it may readily be treated at home. But care

[1] Hallucinations are unreal perceptions of the different senses; thus, seeing a something that does not exist would be an hallucination of sight, hearing something non-existent would be an auditory hallucination, and so on with the different senses of smell, taste, touch, pain, the muscular sense, temperature, and the visceral sensations. Illusions are metamorphoses of real into something unreal; thus, the person looking at an inkstand and supposing it to be a horse, would have an illusion of sight, and so on. A delusion is practically a false belief, although the delusions of the insane usually differ from the false beliefs of the sane in being fixed and uninfluenced by argument or fact. Hallucinations and illusions may be delusive or non-delusive, and delusions may be based on hallucinations or illusions, or accompanied by them, or be without them entirely.

must be exercised not to mistake the mild symptoms of onset of a graver form of insanity for one of continued subacuteness of type. A week or two of time will make this point clear, although the degree of the initial depression and alteration in the patient's character and demeanor will very generally be reliable guides. Most of these cases of mild mania recover within the year, the average course being about five months.

The mild cases of melancholia are also extremely suitable ones for home treatment, when they have either no hallucinations or delusions, or faint ones, when they are not of the agitated or violent variety (the so-called *melancholia agitata*), and when they are without stupor coming on early in the course of the disease, and without attacks of distressing but vague præcordial sensations, to which has been given the name of *præcordial fear*. These mild forms of melancholia are relatively very numerous, and constitute the most frequent form of insanity. The great danger with them is the suicidal tendency, which seems to be the result of the mental suffering of the patient, and which may manifest itself without warning, even in the mildest cases, although the agitated cases, and especially those with præcordial fear, are always the most dangerous ones.

There is a form of acute dementia occurring in young individuals that is of good prognosis, and differs, therefore, very materially in this respect from the dementia which is the consequence of organic brain disease, or which is the terminal and hopeless stage of the unfavorable forms of insanity.

The post-febrile and puerperal insanities constitute a mixed type that is characterized by the acuteness of the symptoms, often by the high temperature and pulse, by the logicality of the delusions, by the sharpness of the hallucinations and illusions, and by the integrity of the consciousness and the memory. These cases are usually of good prognosis.

There is a form of insanity known as the "insanity of doubt" (*folie de doute, mysophobia*), in which the patient does the same thing over and over again, because of doubt as to whether it has been previously done. Thus, a patient having gone through a doorway and shut the door, will return to it again and again to see if it has been shut; or, having washed the hands once, will wash them again and again, because of grave doubt as to whether they are really clean. This form of insanity is one which can be readily treated at home, except in the unusual cases in which it is conjoined with well-marked melancholia or mania.

It is well known that there are certain insanities beginning suddenly in hysterical individuals; there are certain periodical forms of insanity, recurring, as the name implies, with a certain periodicity; there is a form of insanity designated as circular insanity, or *folie a double forme*,

in which an attack of melancholia occurs, is followed by mania, then a lucid interval, and again the melancholia, succeeded by the mania, the intervals varying from months to years—in all these cases the insanity is of a type of mania or melancholia, and if this mania or melancholia is not of the severe type, the cases may be treated at home, although the prognosis will necessarily be very different from that of a simple mania or melancholia.

If an epileptic insanity be not characterized by homicidal tendencies, or such violence as makes the patient dangerous to himself or those about him, it may be treated at home.

There are many slight forms of insanity at the period of pubescence, especially in girls, that ought never, in my opinion, to be sent to an asylum until home treatment has failed, because they are rather the result, so to speak, of physiological excess than of actual pathological alteration. They are characterized by certain morbid beliefs, illusions, and hallucinations that are semi-delusional, and out of which the patient can often be reasoned; by a certain occasional eccentricity of action which is automatic, and at which the patient himself or herself often wonders; and sometimes by a certain confusion of ideas that may last for several weeks. The milder forms of this disease stand just beyond the border-line of mental health, and will often make the impression of affectation or eccentricity, but the severer types may become quite stupid, and continue for months. All the cases that I have seen have recovered.

There is quite a modern literature on what is called the insanity of childhood—*i. e.*, the insanities appearing in both sexes before the period of sexual development. Although the time limit is somewhat arbitrary, the distinction is valuable in a clinical sense. These insanities are of better prognosis than in the adult, whatever the type may be, excepting insanity of direct inheritance, and they may, therefore, be treated at home, as a rule.

The forms of insanity which should be sent to an asylum are:

All chronic insanities;

All forms of insanity characterized by homicidal, suicidal, or violent outbreaks;

Transitory mania;

Paranoia;

The form of insanity known as "katatonia;" melancholia with stupidity, great agitation, or distinctly marked præcordial fear;

General paralysis of the insane;

All forms of dementia constituting the terminal stage of insanities, or that are caused by organic brain disease, or that are senile;

The insanity of masturbation.

In speaking of the chronic insanities, it must be remembered that the terms chronic and acute have a different meaning as related to in-

sanity from what they possess in the nomenclature of general medicine, because even the favorable forms of insanity continue for six months or a year, and are known as subacute cases, whereas the chronic cases may be said to be those that do not show signs of improvement within the year. For the chronic cases an asylum has very many advantages in the continuous discipline and supervision, in the freedom of the grounds, in the many appliances of diversion and occupation, and in the ability to dispense with meddlesome medicine.

All forms of insanity characterized by homicidal, suicidal, and violent outbreaks are best handled in an asylum. The type alone will, in some instances, be indicative of danger in these respects. Thus, as has been said, all cases of melancholia, even the mildest, will have an organic suicidal tendency, although this is much the most marked in the severer forms; and insanity accompanied by delusions leading the patient to fear danger to himself, as when there is delusion of persecution, of being followed, etc., is apt to be dangerous. In other cases, the type alone will not be a safe criterion, and reliance will have to be placed upon the tendencies of the particular case, as the same form of insanity may vary in this regard from patient to patient.

Transitory mania is that form of insanity in which a furious outbreak suddenly occurs, as in the case of the Italian soldier who ran amuck in his barracks and murdered several of his comrades before he could be put under arrest; or as in the case of an individual in Buda-Pesth, told of by Schwartzer, who suddenly attempted to murder his intimate friend and was overpowered with great difficulty. The paroxysms generally last several hours, when a sound sleep occurs, and the patient wakes in his normal mental condition and totally without remembrance of what he has done. These cases are extremely dangerous, because the attacks are apt to occur so suddenly that no warning is given to the patient or those about him, and it is almost impossible to foretell as to how many future attacks there may be. When such cases have done any violence in one of their furious outbreaks, they ought to be locked up in an asylum either for the rest of their life or until such time has elapsed as to render it approximately certain that there is no danger of a recurrence of the paroxysms. Under no circumstances should they be kept at home before it is perfectly safe to do so.

Paranoia is an old term recently revived designating a very chronic form of insanity with logical delusions occurring in the hereditarily predisposed or the neurotic. Its synonym, "reasoning mania," expresses its character better. To this form belong that large class of patients to whom the term "crank" has been applied since the Guiteau trial. These cases should be sent to an asylum.

Katatonia is a disease that was first described in 1874, by Kahlbaum, and is a form of stupid depression associated with cataleptic symptoms.

The patient will sit for hours motionless, mute, and maintain a limb for a long time in any position in which it may be placed. Although opinions differ somewhat as to the prognosis, yet the course of the disease is prolonged and the patients need as much care as an infant, and these facts should be considered in deciding the question of home or asylum treatment.

In melancholia with stupidity the course of the disease is very apt to be chronic, unless the stupidity is of the very slight form that marks the stage of convalescence. If, however, it daily grow deeper and deeper, and be marked by automatic outbreaks of mental and physical activity that may sometimes be violent, it is usually of ill omen. When a case of melancholia has that vague sense of distress in the præcordia to which has been given the technical name of *præcordial fear*, there is always danger of some violent outbreak at the time of the præcordial phenomena, and this can be guarded against better in an asylum than at home; moreover, these cases are of doubtful prognosis. Melancholia with continuous agitation (melancholia agitata) is also apt to be chronic and dangerous.

Any of the graver forms of insanity may pass into a condition of dementia, but such a dementia should be sharply distinguished from the depression of spirits and mental exhaustion which mark the stage of convalescence of a curable insanity. The terminal form of dementia is a very unfavorable symptom. The dementia that is caused by organic brain disease has, of course, the prognosis of the causative malady. Senile dementia is necessarily hopeless.

General paralysis of the insane is, as is well known, a chronic interstitial encephalitis, of remittent character, usually running its course in about three years. It is characterized by certain slight though distinct symptoms in the earlier stages, such as tremor of the tongue and facial muscles, unequal pupils, difficulty of speech, especially in the pronunciation of certain lingual and dental sounds, alterations in the mental character, usually of some grandiose or expansive delusion, exacerbations lasting for a day or two, and during which the patient's face becomes flushed, his gait becomes uncertain, his speech becomes thicker, and he is very apt to do some purposeless act so totally at variance with his previous character as to dumbfound those about him; thus one of my patients, whilst in one of these paroxysms, was handed a flower by his newly wedded wife, and immediately struck her in the face. It is in this early stage, which is dotted with these slight and remittent symptoms, that a mistake in the diagnosis is most apt to be made. Such cases are absolutely incurable, and it is of enormous importance to recognize them promptly, not only because of the uselessness of treatment, but also because early recognition of the disease often prevents

much misery and loss of money or business, by the commitment of the patient to an asylum and the appointment of a trustee of his estate.

By the insanity of masturbation I mean what Dr. Spitzka happily terms an "agitated dementia," occurring in habitual masturbators, and usually of bad prognosis. It is, however, to be distinguished from the ordinary types of insanity, which may occur in masturbators, but which run about the same course as in anybody else.

The weight of the body and the predisposition of the patient are prognostic factors of considerable moment. It is a well-established fact that the loss of bodily weight in the curable insanities is not extreme, and that it continues to decrease with the development of the mental disease, and should, in favorable cases, only return to the normal in the period of convalescence; so that a full return of the bodily weight, without corresponding restoration of the mental integrity, would be a very unfavorable symptom. Then, too, it is a curious fact that a mild predisposition and second attacks are not unfavorable factors. Thus, in 33,318 cases collected by Dr. Pliny Earle, the percentage of recoveries in the first attack was 29.15 per cent., and in 93,443 cases of Chapman's it was 37.95 per cent.; whereas, Earle collected 4768 cases of second attack, in which the recoveries were 55.57 per cent., and Chapman collated 19,574 similar cases, in which the recoveries were 53.61 per cent.[1]

As most insanities, especially the curable forms, are self-limited diseases, each type varying in its course from a few weeks to a few years, treatment is largely expectant, and its objects should be:

To protect the patient and those around him;

To control the unnecessary expenditure of energy;

To control fever, if there be any;

To relieve insomnia;

To maintain the general health.

One of the first necessities of the treatment of a mental disease is that the patient and those around him should be protected from the irresponsible acts that may be induced by the mental disease. To this end it is absolutely necessary that there should be somebody in charge of him constantly, that dangerous instruments should be withdrawn from his reach, and a constant guard should be maintained in cases of melancholia against the suicidal tendency. In the mild forms of mania, in primary dementia, in the insanities of pubescence that have been described, and in many insanities of childhood, the danger of suicide or violence is very small, and these patients need have no alteration made in the furniture or their rooms, nor do they need any fixtures to the windows. Whilst there are many cases of mild melancholia in which

[1] The Curability of Insanity. By Pliny Earle. Philadelphia, 1857.

no suicidal impulse is developed, it should never be forgotten that this form of insanity is extremely treacherous in this respect, and it will never do to be off one's guard. Most cases of the insanity of doubt are perfectly harmless, but a strong suicidal tendency may develop upon slight provocation if the mental depression becomes very pronounced. The post-febrile and puerperal insanities may need constant attendance during the acute period, but are generally harmless in the later stages, and the same is generally true of the hysterical, periodical, and circular insanities.

If the patient shows a tendency to excitement and consequent undue expenditure of mental and physical energy, it is usually well to diminish this, and some mild cases will recover at once when this is done. The best drugs for this purpose are the bromides, opium, and hyoscyamine, but in using any of these great care should be taken not to depress the patient. The bromides alone will usually control only the mildest forms, and they must therefore be combined with one of the two others. It is a singular clinical fact, if I may judge from my own experience, that hyoscyamine is usually best fitted for the cases of mania, whilst it excites the melancholiacs, in whom opium has a sedative effect. The variety of hyoscyamine which I like best is the crystallized variety made by Merck, and which is put up in tablets of gr. $\frac{1}{100}$ by all the drug-houses. The dose should be gr. $\frac{1}{100}$ to gr. $\frac{1}{60}$ once or twice a day; even greater doses may be given, but they should be administered with great caution. Care must be taken constantly to ascertain whether the patient is suffering from any urinary retention which hyoscyamine is apt to induce temporarily, but which is usually harmless, although in some quite exceptional cases it may produce strangury, and should then be discontinued, at least temporarily. The uncrystallized hyoscyamine has not done so well in my hands, and the hyoscyamus of our pharmacopœia is well nigh useless. The preparation of opium in which I have the most confidence is that which has been so highly recommended by the German authors, the aqueous extract. This is now put up for me in hypodermic tablets by Mr. Fraser. In some cases of melancholia this aqueous extract, administered hypodermically twice a day, will have a markedly beneficial effect. The commencing dose should be gr. $\frac{1}{4}$, and this should be increased according to the judgment of the physician. If it has a beneficial effect, it may be continued for weeks, and should not be suddenly stopped, but the terminal doses should be gradually diminished. It seems to have quite a different effect from morphia, especially in the infrequency with which it causes constipation, and there is far less risk in forming a habit than with morphine. The combination of one of the bromides, preferably that of potash, with hyoscyamine on the one hand or with opium on the other increases the sedative effect of each drug without adding to the depression—a thera-

peutic fact to which I called attention a number of years ago. Sometimes a very happy effect can be attained by the combination of the three drugs, especially in cases of mania occurring in healthy individuals.

In post-febrile cases occurring after attacks of peritonitis and typhoid fever, and in some of the puerperal cases, the fever may range from 101° to 104°, and is apt to cause considerable anxiety and lead to the most energetic attempts at reduction. As long as the ingestion of food remains good and the patient's strength is maintained, this fever need not excite much alarm, and the attempts to reduce it by large doses of quinine and antipyretics are often much more injurious than the febrile movement itself. It should be carefully watched, as we watch the temperature in a case of typhoid, and if it runs too high, it should be met temporarily by proper antipyretic means, which should not be employed needlessly. Antipyrin and antifebrin will often act very well temporarily; so will a cold pack; but very often the most efficient remedy, if the patient's strength or abdominal lesion will permit of it, is an active saline purge, followed by a few grains of quinine and a few extra doses of alcoholic stimulant.

In melancholia the insomnia is apt to be a very distressing symptom, as well as to aggravate the disease. The best remedies to overcome it, in the order in which I catalogue them, are sulphonal, urethan, paraldehyde, chloral hydrate. Sulphonal and urethan are attended by no disagreeable symptoms whatsoever, and are therefore the most desirable of all of these, if they will act. Sulphonal is, unfortunately, very expensive and very insoluble. To overcome the last difficulty, it has been suggested that it should be given several hours before bedtime, and in a bowl of soup; but if this last is not feasible, it may be administered in a wafer or in a simple powder. The dose should be gr. xxx, to be repeated within an hour if needed. It will often produce four to six hours of very refreshing sleep. Urethan, in doses of gr. x to xxx, may be administered in solution, and often has an equally good effect. Paraldehyde has the great disadvantage of often imparting a very disagreeable odor to the breath that will continue for days, although it, too, often induces good sleep. This odor to the breath can be sometimes overcome by the administration of tincture of bitter orange root, as Krafft-Ebing has suggested. The dose is ʒj to ij. Chloral hydrate is, after all, the most efficacious of all these hypnotics, but it is very prone to depress the patient and to endanger a chloral habit. Trial should, therefore, be made with suphonal, urethan, and paraldehyde before chloral hydrate is used; but the medical attendant should satisfy himself that the patient's statement about the degree of insomnia is correct, for a person suffering from insomnia is very apt to exaggerate the matter. All these hypnotics, with the possible exception of sulphonal, should be given at about the usual hour of going to sleep, the room

should then be darkened, and the utmost possible quietude should be maintained. It is often extremely advantageous, especially in cases of melancholia, to give a glass of egg-nogg or a generous dose of malt extract at bedtime, or a cup of hot chocolate, and in the milder cases or in the convalescent stage a light supper may be combined with these.

Tonics and alteratives may be administered in these curable forms of insanity, according to the rules obtaining in general medicine. Quinine, cod-liver oil, and the malt extracts are most useful. Phosphorus is occasionally a most excellent tonic in the later periods of convalescence, and should be given in the formula first proposed by Ashburton Thompson.[1] Galvanization of the cerebrum and the spinal cord is an invaluable aid in the treatment, especially in the cervical and occipital neuralgias that are so apt to follow attacks of melancholia. Galvanization of the cerebrum should be very carefully done, one large electrode (about four to five inches) being placed upon the forehead, another of equal size upon the occiput, and a gentle current of three to five milliampères passed for a period varying from two to five minutes. Great care should be taken to avoid any interruption in the current. Galvanization of the spinal cord should be done by means of electrodes, of the size just mentioned, upon the upper cervical and lower dorsal cord respectively, but a much larger current should be employed, ranging from five to fifteen to twenty milliampères, and the sitting lasting from five to fifteen minutes. General faradization is also often of great use. In some cases the electric breeze from a static or Holtz machine is extremely beneficial to the patient.

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PULSATING PLEURISY.[2]

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Pulsating pleurisy is such a rare condition that the following case is worth placing upon record:

Strain in lifting: pain in left side; rapid effusion, at first serous, necessitating two aspirations; pyo-pneumothorax; pulsation of side; free drainage; recovery.—James F., aged twenty-three years, laborer, was admitted to the University Hospital March 3, 1888. Family history

[1] Phosphorus one grain, absolute alcohol five drachms, glycerine one and one-half ounces, spirit of wine two drachms, spirit of peppermint two scruples; dissolve the phosphorus in the alcohol with a little heat, at the same time warm the spirit and the glycerine together. Mix the two solutions while hot, and add the spirit of peppermint on cooling. Dose one-half a drachm to two drachms.

[2] Read by title at the meeting of the Association of American Physicians, Washington, 1888.